TO: Assembly member Jim Beall, Chair of Select Committee of Alcohol and Drug Abuse

FROM: Michael S. Dukakis Chair Blueprint For The States Report and Sydney Gardner, member of the panel, Blueprint for The States Report on behalf of the entire panel

RE: Testimony Submitted for the record for August 30, 2007 hearing

Submitted by Michael S. Dukakis, former Governor of Massachusetts and Chair, Blueprint for the States Report m.dukakis@neu.edu
and Sydney Gardner, President ,Children and Family Futures and panel member, Blueprint for the States Report sgardner@cffutures.org on behalf of the entire panel.

The following comments are based on the Join Together Blueprint for the States Report on ways states can improve organization and delivery of alcohol and drug services

Blueprint Overview

Process, Panel and Executive Summary: 6 key points

The panel's eleven members, chaired by Gov. Michael Dukakis, met four times, held hearings in Santa Fe, N.M., and Washington, D.C., received written testimony, and reviewed research and existing models. The panel heard from experts, clients, providers, government officials and community leaders, while drawing upon panel members' own extensive experience in state government.

Six key points summarize the findings of the panel:

Leadership

Governors, legislative leaders and chief judges need to provide personal, continuous leadership for a statewide strategy to prevent and address alcohol and drug problems. When prevention and treatment are delegated to mid-level state agencies, states can not successfully prevent or treat drug problems at the population level.

Structure

Every state should have a strategy that encompasses all the agencies affected by alcohol and drug problems. Responsibility for state and federal prevention and treatment funds should be held by an entity that reports directly to the governor and has direct access to the state legislature.

Resources

States can generate two key resources needed to improve alcohol and drug services: money and skilled practitioners. An annual public report should detail alcohol and drug related spending in all state agencies. If additional funds are needed, states should consider raising alcohol taxes. States should also use their licensing and educational resources to improve and retain the prevention and treatment workforce.

Measurement and Accountability

States should hold agencies and contracted providers accountable for meeting identified outcome measures. They should reward those that meet or exceed

outcome targets and penalize those that consistently fail.

Legislation

States should review and update the legislation that controls their alcohol and drug policies including authorization for prevention and treatment agencies and alcohol control boards. Laws and regulations that prevent recovering individuals from getting jobs, education and other services needed for successful reintegration should also be reviewed and repealed. Review sentencing to include treatment. Parity that includes coverage for alcohol and drug problems as a core insurance benefit should be passed. The Uniform Accident and Sickness Policy Provision Law (UPPL) should be repealed.

Sustain State Focus and Attention

State advisory councils should be created or revived with enough staff and authority to hold elected officials accountable for providing needed leadership. States should support community coalitions and recovery organizations to build a lasting constituency for continuing effective state action.

We came to these recommendations after developing a set of basic principles, on which the Panel achieved a strong consensus:

- Alcohol and drug problems occur within the context of families and communities. Children often suffer because of untreated adult alcohol and drug problems in their families and neighborhoods. Their exposure to alcohol and drug use places them at high risk for developing their own substance use problems. Children growing up in these circumstances should receive special attention from health, education, social services and juvenile justice agencies.
- Alcoholism and drug addiction are treatable and preventable diseases. We believe states should address them through a public health strategy with the goal of long-term recovery.
- Health care for general, mental and substance use problems can be delivered with an understanding of their interconnections. Payment streams and policies that create or reinforce institutional barriers to a patient-centered focus should be identified and changed.
- We find that criminal behavior under the influence of alcohol or drugs cannot be excused, but punishment alone – without equal attention to treatment and reintegration – is expensive and ineffective. We believe every person entering or under the control of the criminal justice system should be assessed for alcohol and drug problems; provided with high-quality physical health, substance use and mental illness treatment; and be connected with community-based treatment and recovery services to help reintegrate them with family, work and the community when released.
- We find that there is an economic imperative for governors and legislators to provide leadership on substance use issues. Unless they do, governors may not have the resources they need to meet many of their other objectives. From 9% to 77% of critical state functions including criminal justice, health, and law enforcement are affected directly by alcohol and illegal drugs, with costs spread throughout the entire state government.

Six sets of numbers summarize the voluminous material presented to the Panel:

- Between forty and eighty percent of families in the child welfare system have alcohol or other drug problems, and a majority of children in foster care come from families with drug or alcohol problems.
- More than half of all state prison inmates were under the influence of alcohol or drugs when they were arrested.
- Nearly one in six state inmates committed their crimes to support a drug addiction.
- Drunk driving is a major expense to the police, courts and emergency medical systems.
- About 20 percent of acute Medicaid expenditures pay for alcohol or drug related medical costs.
- States spend around 13% of their entire budgets responding to problems caused by substance use.

Despite the importance of these issues in human and financial costs, our Panel concluded that no state today is able to pull together a comprehensive overview and the resources to address these issues strategically. Piecemeal, fragmented efforts are the norm, with very few states able to fully inventory what they are spending or issue an annual score card of the results achieved by these resources across state agencies.

And yet in every state we looked at, reforms are under way that have the potential to pull the pieces together. States are strengthening their training and accountability systems, improving their capacity to work across agency lines, and cooperating with local and community-based providers with an excellent track record of helping parents and children affected by substance use disorders.

Finally, our recommendations for action in the short run are straightforward, and track well with several of the steps we understand you and your staff have already taken:

1. It is essential to start with a better handle on all of the pieces of state government that are affected by substance use disorders—you have to take inventory, as our report says. If we are not clear on who is doing what, it will be very difficult to develop strategy across all of these agencies. As an example, Oregon has recently developed a matrix of all of its programs that address the problem of prenatally exposed newborns, which compiles in one place data that has never been aggregated. Legislatures can mandate compliance with reporting requirements ion which state agencies that say they do not have the resources to compile information can be challenged to do so by mobilizing those resources from within and in partnership with academic institutions. Some states have found that they are not enforcing their own requirements for information, including some on the area of prenatal exposure of infants to drugs and alcohol. Others have reviewed their use of Medicaid for treating substance use disorders and linking with other funding streams, as some localities in California have begun to do in coordination with your Mental Health Services Act resources under Proposition 63.

2. It is critical to take advantage of those areas where new federal resources and mandates offer leverage. We can debate whether the federal government has fully redeemed its promises about a “war on drugs.” But there are definitely areas in which leadership has been provided, and states need to respond in depth to each of these. Among those are

- The National Outcomes Monitoring System (NOMS), which states need to invest in to be able to better track the relationship between their own resources and results achieved with those resources; this may enable better reporting than has been possible in the past with California's problematic reports of only 4% incidence of substance use disorders among the foster care population;
- The new requirements under the Children's Bureau for better reporting and developmental assessments of children affected by their parents' prenatal and postnatal use of drugs and alcohol;
- The new funding streams developed under the Children and Family Services Improvement Act, with special emphasis upon partnerships for treatment services to respond to methamphetamine and its effects. California may receive funding for a number of these, which will be announced very shortly.

3. States need to review how effectively they are using the analytical tools that are already available. In testimony to our Panel, Tom McClellan and others described work under way in Delaware and other sites that addresses the great need for better treatment monitoring tools that can allocate funding toward the best and most thoroughly evidence-based programs and away from those that are ineffective. Legislative committees can conduct annual reviews of trend lines in performance using a "dashboard" of the highest priority measures of the effectiveness of drug and alcohol treatment programs for different populations and different drugs. This sustained attention to key indicators is far more effective than crisis-driven hearings on issues of momentary interest. For example, in California, it is possible to assess the need for adolescent treatment using the biennial Healthy Kids data compiled in school surveys, as Napa County has begun to do; but few counties have thus far linked these two data sets to make a case for investing in programs targeting underage drinking.

4. Our report also mentions the importance of statewide advisory bodies, community coalitions, and organizations of those in recovery. California is rich in these organizations and convening them in broader gatherings that cut across their categorized interests may build wider coalitions in support of expanded investments in treatment and prevention.

We welcome the opportunity to provide these comments for your consideration and would look forward to any additional help we could give you and your committee as you address these vital issues.